Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST PAUL MEDICAL CENTER
PO BOX 201345
ARLINGTON TEXAS 76006

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-98-B570-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for consideration in this dispute.

Amount in Dispute: $2,356.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has paid $3,534.47 toward the disputed bill… Bills were properly paid pursuant to the per diem rates and other provisions of the 1992 Acute Care Inpatient Hospital Fee Guideline… The requestor has failed to meet its burden to show that the reimbursement received was insufficient under the requirements of the Texas Labor Code. Therefore, Carrier requests a determination that the requester is not entitled to further reimbursement for the dates of service at issue."

Response Submitted by: Flahive, Ogden & Latson, 504 West 12th Street, Austin, Texas

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 1997 thru July 17, 1997	Outpatient Hospital Services	$2,356.28	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.

3. This request for medical fee dispute resolution was received by the Division on May 4, 1998.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 632 U–Unnecessary medical treatment or service
   - 389–Charges were reviewed by fair and reasonable guidelines for hospital in Texas
   - 613 F–The reductions in payment are made to the Texas Workers' Compensation Commission established fee guidelines

Findings

1. §134.600, effective December 23, 1991, 16 TexReg 7099, titled *Procedure for Requesting Pre-Authorization of Specific Treatments* states, "(a) The insurance carrier is liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subsection (h) of this section, required to treat a compensable injury, when any of the following situations occur:… (2) the treating doctor, his/her designated representative, or injured employee has received pre-authorization from the carrier prior to the health care treatments or services;…" Review of the documentation submitted indicates that preauthorization was obtained prior to services rendered under precertification # 540762. Therefore, the disputed charges will be reviewed according to the applicable rules and statutes.
2. This dispute relates to outpatient medical services. The services in dispute were not identified in an established fee guideline during the disputed dates of service; therefore, reimbursement is subject to the provisions of 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) until such period that specific fee guidelines are established by the commission."
3. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
4. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of medical records and EOBs or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
5. 28 Texas Administrative Code §133.305(d)(10), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "a summary of the requesting party's position regarding the dispute." Review of the documentation submitted by the requestor finds that the request does not include a summary of the requesting party's position regarding the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(10).
6. Review of the submitted documentation finds that:
   - The requestor did not submit a position statement for consideration in this dispute.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305(d). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 21, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.